TENNESSEE ALCOHOL AND DRUG

BEST PRACTICE GUIDELINES

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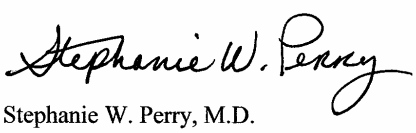
FOREWORD

The Tennessee Department of Health, Bureau of Alcohol and Drug Abuse Services, in collaboration with the Tennessee Department of Mental Health and Developmental Disabilities, and along with the professional experts, are pleased to share with you the Tennessee Alcohol and Drug Best Practice Guidelines document. This document has been produced after a year-long effort of research, discussions and collaborations of partnerships to develop a feasible, comprehensive guide for the establishment of best practice procedures for alcohol and drug services within the State of Tennessee. This document should be used by administrators, clinicians and others to give direction for the best quality of care standards for alcohol and drug programs, including definitive screenings and assessments and appropriate treatment placement decisions. We have utilized a model, which includes a description of universal screening and utilization of the ASAM PPC-2 criteria[1], that is recommended for all Tennessee publicly-funded treatment programs.

This document also highlights several policy issues concerning A&D best practices, discusses issues affecting adolescents and the elderly and recognizes the importance and the priority of best practices for the co-occurring population.

Colleagues, please use this document as a guideline when appropriate. We welcome your comments.



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[1] ASAM American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, ASAM PPC-2, 1996

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I. VISION STATEMENT

TENNESSEE ALCOHOL AND DRUG BEST PRACTICE GUIDELINES

The Tennessee Department of Health, Bureau of Alcohol and Drug Abuse Services has taken the lead in the development of a statewide best practice guideline document for substance abuse services. This document was initially developed to meet the requirements of the Memorandum of Understanding between the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) and TennCare, and to serve as a template for the development of current best practice standards for the State public substance abuse system. This process is a partnership with TDMHDD, providers and substance abuse professionals.

The vision of the Bureau of Alcohol and Drug Abuse Services and this committee is that this set of best practice guidelines be used as a guide for all publicly-funded substance abuse services in the State of Tennessee including those funded through TennCare/Medicaid, Substance Abuse Prevention & Treatment (SAPT) Block Grant, Department of Children's Services (DCS) contracts and others.

This document is the result of a review of available literature. Information was extracted (as referenced) from cited sources.

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In addition, special thanks are extended to the Managed Care Services Division of the Bureau of Alcohol and Drug Abuse Services for their input on this document.

II. INTRODUCTION

TENNESSEE ALCOHOL AND DRUG BEST PRACTICE GUIDELINES

The Nature of Addiction

- Addiction is a progressive, chronic, primary, relapsing disorder.
- It generally involves compulsion, loss of control, and continued use of alcohol and other drugs despite adverse consequences.
- Addiction, treatment, recovery, and relapse are all dynamic biopsychosocial processes. That is, they are processes influenced by biological and medical factors, psychological and emotional factors, and social and environmental factors.
- In turn, these factors are influenced by addiction, treatment, recovery, and relapse.
- The primary goal of addiction treatment is to meet the treatment needs of clients. These needs are biological, psychological, and social in nature.
- Accordingly, the effectiveness of treatment can be measured in terms of the overall biopsychosocial health of clients, including such factors as decreases in substance use, improvements in medical and physical health, improvements in psychosocial functioning, greater employment stability, decreases in criminal justice system involvement, and relapse prevention preparedness.

(Overview of Addiction Treatment Effectiveness, U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, February 1997).

Treatment Effectiveness: Does Treatment Work?

First, research to date has conclusively established that treatment can be effective, but there are only preliminary indications at this time as to why treatment is effective or what it is within treatment that mak es it effective.

Second, some clients have better prognoses at the start of treatment than others. The variables that suggest better prognosis include:

- low severity of dependence and psychiatric symptoms at admission;
- motivation beyond the pre-contemplation stage of change;
- being employed or self supporting; and
- having family and social supports for sobriety.

Third, some treatment variables have been reliably shown to produce better and more enduring outcomes. The treatment variables associated with better outcome in rehabilitation include:

- staying in treatment (at least outpatient treatment) longer and being more compliant with treatment;
- having an individual counselor or therapist and more counseling sessions during treatment;
- receiving proper medications – both anti-craving medications and medications for adjunctive psychiatric conditions;
- participating in voucher-based behavioral reinforcement interventions;
- participating in AA, CA or NA following treatment; and
- having supplemental social services provided for adjunctive medical, psychiatric, and/or family problems.

Clearly, more research is needed to identify the "active ingredients" of treatment and the minimal effective dose of those ingredients.

(Principles of Addiction Medicine, Second Edition, American Society of Addiction Medicine, Inc., 1998, page 338)

Cost Effectiveness

Drug addiction treatment is cost-effective in reducing drug use and its associated health and social costs.

- Treatment is less expensive than alternatives, such as not treating addicts or simply incarcerating addicts.
- For example, the average cost for 1 full year of methadone maintenance treatment is approximately $4,700 per client, whereas 1 full year of imprisonment costs approximately $18,400 per person.
- According to several conservative estimates, every $1 invested in addiction treatment programs yields a return of between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft alone.
- When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1.
- Major savings to the individual and society also come from significant drops in interpersonal conflicts, improvements in workplace productivity, and reductions in drug-related accidents.

(Principles of Drug Addiction Treatment: A Research-Based Guide, National Institute on Drug Abuse, National Institutes of Health, NIH Publication No. 99-4180, October 1999, page 21)

Statistics

- Every man, woman and child in America pays nearly $1,050 each year to cover the $276 billion total national costs of untreated substance abuse.
- In contrast, it would cost about $45 per year, per each American to provide the full continuum of services needed to effectively treat addictive disorders.
- The public health care costs related to substance abuse provided through Medicaid are enormous:
  - $ 776 Million for addictive disorders
  - $ 112 Million for diseases attributable to substance abuse
  - $ 2,933 Billion for diseases for which substance abuse is a risk factor
  - $ 336 Million for clients with a secondary diagnosis of substance abuse

- Over 72 medical conditions have risk factors attributable to substance abuse.
- Blue Cross/ Blue Shield found that families' health care costs dropped by 87% after treatment.
- Data from across the nation prove the effectiveness of treatment in reducing crime. Studies in various states show that treating prisoners / offenders results in:
  - lower rearrest rates;
  - higher abstinence rates;
  - decrease of jail days served;
  - drop in drug-related offenses;
  - drop in driving while intoxicated;
  - drop in violent crimes, domestic violence, and property crimes; and a
  - drop in the number of people convicted.
- Treatment is a good investment because it:
  - reduces health care costs;
  - cuts costs of crime, violence and law enforcement;
  - reduces welfare costs;
  - restores families;
  - yields returns to business; and
  - is affordable.

(Substance Abuse *in brief*, Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration, U. S. Department of Health and Human Services, January1999, December 1999 and May 2000).

III. ASSESSMENT SECTION

TENNESSEE ALCOHOL AND DRUG BEST PRACTICE GUIDELINES

General Outline

1. Goals of Screening and Assessment
    A. Screening
    B. Provider Competencies for Assessment
    C. General Principles of Comprehensive Assessment

2. Patient Placement Criteria
    A. Benefits of Standardized Placement Criteria
    B. American Society of Addiction Medicine Patient Placement Criteria, Second Edition-Revised, (ASAM PPC-2R) Assessment Dimensions
    C. Recommended Assessment Practices
    D. Objective Information versus Clinical Subjectivity
    E. Use of Assessment to Guide Placement Decisions Using ASAM Criteria

3. Special Issues
    A. Assessment of Children and Adolescents
    B. Assessment of Co-Occurring Psychiatric and Developmental Disabilities

4. Comprehensive Assessment Provides a Foundation for Treatment Services

1. Goals of Screening and Assessment

Screening and Assessment activities have four broad goals :

- to identify and confirm the presence of substance use disorders;
- to determine an appropriate, individualized treatment plan;
- to recommend appropriate placement based upon clinical indicators; and
- to engage the client and to provide a solid clinical foundation for subsequent treatment.

The Tennessee Department of Health – Bureau of Alcohol and Drug Abuse Services endorses diagnostic criteria provided by the American Psychiatric Association in the DSM-IV for determination of substance abuse and dependence. The Bureau further acknowledges and endorses the bio-psycho-social aspects of mental health and substance use disorders.

Responsible screening and assessment, however, serves a more important purpose than simply providing a diagnostic classification. Screening and assessment typically provide the first opportunity to engage the client, identify problems, generate solutions, develop treatment plans, and determine optimal placement.

Screening provides the first step toward identification of substance use disorders, and is typically characterized by gathering and sorting of information in order to determine whether an individual has a substance use problem, and if so, whether detailed clinical assessment is necessary [Center for Substance Abuse Treatment (CSAT), Treatment Improvement Protocol (TIP) Series #7, page 3]. Comprehensive clinical assessment builds upon initial screening activities by collecting detailed information concerning the client's substance use, personal history, emotional and physical health, social roles, and other relevant areas (TIP #7, page 2). While assessments typically include a common set of information across clients, each assessment should also address individual-specific domains as determined by the clinical judgment of the interviewer. A truly comprehensive assessment may often require the involvement of other health professionals as appropriate, including physicians and mental health specialists.

General principles and key activities of screening and assessment are described as follows:

1A. Screening – (TIP #7, page 13-)

- The goal of screening is to identify candidates for early treatment intervention in order to break the cycle of abuse and dependence (TIP #7, page 15-).
- Screening does not require extensive training, but begins with an awareness and recognition of factors relevant to substance use decisionmaking, and includes listening and noticing behavior and actions (TIP #7, page 13).
- Substance abuse screening may be conducted in a variety of settings, including primary care, mental health facilities, and criminal justice settings. In the event of a positive screen for substance abuse or dependence, an appropriate referral should be made for a comprehensive assessment by a substance abuse treatment professional.
    - Recommended substance abuse screening tools for use in non-substance abuse treatment settings include the CAGE and the MAST

- Correspondingly, substance abuse treatment staff has a responsibility to screen for the presence of additional physical or mental health issues that may complicate treatment. If it appears that a client is experiencing physical or mental health symptoms, he or she should receive a thorough assessment by an appropriate professional.

1B. Provider Competencies for Assessment – [Center for Substance Abuse Treatment (CSAT), Technical Assistance Publication (TAP) Series #21; TIP #13, page 37; TIP #7, page 7]

- The client will be evaluated by personnel with training and expertise to conduct a comprehensive biopsychosocial assessment. It is recommended that intake assessment responsibilities be conducted by veteran, experienced clinical staff because assessment dictates subsequent placement and treatment planning decisions. If it is necessary for junior staff to conduct assessments, senior staff will be available for supervision and consultation.
- The provider shall demonstrate the following skills related to assessment (TAP #21):
  - ability to establish rapport;
  - knowledge of appropriate measures/instrumentation;
  - ability to gather data from client and other collateral sources;
  - awareness of the role of developmental issues, culture, gender, and disabilities;
  - ability to screen for immediate risks due to toxicity, intoxication, withdrawal, danger to self or others, and mental health problems;
  - use of appropriate supervision and consultation;
  - ability to assist client in identifying impact of substance use on life problems;
  - ability to determine readiness for treatment and stage of change;
  - ability to review appropriate treatment options with consideration of client's needs, characteristics, goals, and resources;
  - ability to apply Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) criteria for diagnosis of substance use disorders;
  - ability to apply ASAM PPC-2 criteria for placement decisions;
  - ability to construct an action plan with client to address needs;
  - ability to initiate the action plan and ensure follow through; and
  - ability to document the assessment and placement process.

1C. General Principles of Comprehensive Assessment

- Timeliness
- Sensitivity to age, gender, racial, ethnic cultural issues, and disabilities
- At a global level, a model assessment should include (TIP #13; TAP #21):
  - Client participation and ongoing feedback;
  - Current status of substance use from the client's perspective;
    - type of substance, quantity, frequency (especially last 30 days), onset
    - consequences of substance use (in all life domains)
    - context of substance use
    - control of substance use (e.g., awareness of how one makes decisions to use substances)
    - factors that contribute to substance use, i.e., goals or reasons.
  - Current status of physical health, and mental health;

- History of substance use, physical health, and mental health;
- Treatment history of substance use, physical health, and mental health;
- Assessment of developmental disabilities/mental retardation;
- Family/social history and current issues;
- Work history and current employment issues;
- Educational history and current learning issues;
- History of criminality and current legal status;
- Spirituality (and role in recovery);
- Review of nutritional needs;
- Basic life management skills;
- Socioeconomic characteristics and lifestyle;
- Use of other services and community resources; and
- Review of eligibility for public health, welfare, employment, and educational assistance programs.

♦ Domains of SA assessment (justify multidimensional assessment) (TIP #7, page 15-)
  - Thorough assessment of substance abuse is an ongoing process
♦ Importance of history, previous treatment records
♦ Serum and urine toxicology may be indicated in certain settings
♦ Importance of collateral verification
♦ Appropriate referral for medical issues
♦ Appropriate referral for psychiatric assessment (50% likelihood of dual diagnosis)

Formal and informal assessment should occur on an ongoing basis during the treatment process. Documentation of ongoing assessment should be made as required by BHO and state requirements.

Today, in the alcohol and other drug abuse treatment (AOD) field, there is a movement toward using individualized, targeted treatment models to ensure access to quality treatment and conserve healthcare resources. Now clinicians must focus on matching patients to individually tailored treatment, rather than on forcing clients into in established treatment regimen. The success of clinically driven treatment depends on recognition of the initializing and maintaining processes underlying maladaptive decisionmaking.

Assessment can be a bridge between a person's decision to utilize substance abuse treatment services and the change processes resulting in a life with no or reduced substance use. When treatment services are limited and every moment of service provision is important, assessment should serve the purpose of increasing the client's awareness of those specific cognitions that affect control over substance use as well as their reactions to treatment.

2. Patient Placement Criteria

In order to ensure the most appropriate, most individualized treatment process, the assessment information must first be used to recommend an optimal level of care. The optimal level of care should be the least restrictive level of care that provides the service array sufficient to meet the client's needs. In order to facilitate this placement process, several models of patient placement criteria have been developed:

2A. Benefits of Standardized Placement Criteria – (TIP #13)

- Placement criteria provide a common language describing the dimensions of assessment, and the components of the continuum of care can enable clinicians (and payors) to consult about clients or program characteristics without confusion (TIP #13, page 1).
- Standardized placement criteria can help alleviate the high cost of undertreatment by ensuring that patients get *all* the treatment they need, based on clearly-articulated continued stay criteria rather than arbitrary monetary or time limitations (TIP #13, page 1).
- Standardized placement criteria can help alleviate the high cost of overtreatment by ensuring that patients get *only* the treatment they need, based on clearly-articulated continued stay criteria (TIP #13, page 2).
- A set of common placement criteria provides a unified framework regarding levels of care, assessment standards, and continued stay criteria for use on both the public and private sectors.

Given the clear benefits accompanying use of uniform patient placement criteria, the Tennessee Department of Health – Bureau of Alcohol and Drug Abuse Services endorses use of the ASAM PPC-2R framework in the State of Tennessee.

The ASAM PPC-2R provides a generalized framework of patient placement criteria, describing a comprehensive system for individualized assessment, treatment planning, levels of care, continuing care criteria, and utilization management. The breadth of the ASAM framework is both a strength and a weakness, allowing ASAM principles to apply across a diverse array of clinical settings, but failing to specify clear standards for assessment and placement for each setting.

In Tennessee, ASAM guidelines provide a common set of clinical criteria for providers across a variety of clinical settings, outlining an integrated approach to assessment and specifying six clinically significant dimensions. While the ASAM provides general guidelines regarding the use of key clinical dimensions in determining level of care and treatment plans, it does not dictate specific modalities of assessment. It is expected that treatment providers in Tennessee will utilize the ASAM framework in conjunction with specialized knowledge of their treatment setting and clientele to select assessment tools appropriate for the ASAM context. As outlined earlier in this document, "General Principles of Comprehensive Assessment" should be followed at all times.

2B. ASAM PPC-2R Assessment Dimensions – (ASAM Manual)

ASAM criteria dictate that comprehensive assessment will include the following domains:

- acute intoxication and/or withdrawal potential;
- biomedical conditions and complications;
- emotional/behavioral conditions and complications;
- treatment acceptance/resistance;
- relapse/continued use potential; and
- recovery/living environment.

A comprehensive assessment of each of these clinical domains, and perhaps others as dictated by clinical need, is required in order to make appropriate placement decisions, to develop individualized treatment plans, and to determine eligibility for continued stay. The purpose of this comprehensive assessment framework is to ensure that each individual seeking alcohol and drug treatment services in Tennessee receives the appropriate clinical services in the least restrictive environment possible. A brief description of each dimension follows (this section is based upon page 14 in the ASAM PPC-2 Manual and is outlined in further detail therein. Note that slight changes have been made to several dimensions in the ASAM PPC-2R):

Dimension 1: Acute intoxication and/or withdrawal potential

- Assess risk associated with withdrawal from substances.
- Consider the type of substance, including amount used and frequency.
- Consider the recency of discontinued use.
- Assess clinical signs of current withdrawal (may use CIWA-Ar).
- Consider available supports if ambulatory detox is recommended.
- Assess previous withdrawal and seizure history (have there been complications in the past?).

Dimension 2: Biomedical conditions and complications

- Assess status of physical illnesses, both current and previous, chronic and acute.
- Consider need for medical support while in treatment for substance use.
- Consider the impact of existing physical illness on treatment for substance use.

Dimension 3: Emotional/behavioral conditions and complications

- Assess the psychiatric, emotional, and behavioral status of the client.
- Conduct differential diagnosis to differentiate symptoms related to psychiatric disorders from symptoms related to substance use.
- Does the client have any non-substance-related DSM-IV diagnoses or symptomatology?
- Consider how the presence of a psychiatric disorder may impact treatment for substance use.
- Consider the need for simultaneous mental health services or fully integrated treatment.
- Consider the impact of developmental disabilities/mental retardation on treatment needs.
- Consider the role of substance use in the psychiatric problems, and vice versa, consider the role of psychiatric problems on ongoing substance use. An understanding of the interdependence of substance use and psychiatric problems may suggest treatment strategies.
- Formal diagnoses of psychiatric or developmental disabilities should be made by qualified clinicians.

Dimension 4: Treatment acceptance/resistance

- How ready is the client for treatment?
- Has the client been coerced to enter treatment (e.g., family pressure or legal issues)?
- Does the client accept that he or she has an addiction problem that needs treatment?
- Is the client self-motivated to change, or externally-motivated?
- Consider the client's status in terms of Prochaska and DiClemente's Transtheoretical Stages of Change model (i.e., precontemplation, contemplation, preparation, action and maintenance).
- Consider how one's readiness to change will affect the delivery of treatment services.

Dimension 5: Relapse/continued use potential

- Is the client in immediate danger of continued substance use behavior?
- Consider the client's pattern of recent substance use, the severity of addiction, and the likelihood of continued use.
- Evaluate the client's awareness of his or her relapse triggers.
- Consider the client's skills and resources to effectively prevent relapse and/or cravings.
- Consider the probable severity of problems likely to occur if not successfully engaged in treatment.

Dimension 6: Recovery/living environment

- Assess the client's living environment for situations that may threaten treatment engagement and successful recovery.
- Consider the possible negative influence of family, friends, living environments, and working situations when making this determination.
- Likewise, assess the client's living environment for the presence of positive influences that may benefit treatment and recovery efforts.
- Positive factors may include supportive relationships, financial resources, or educational/vocational resources.

2C. Recommended Assessment Practices

While there are a variety of approaches to assess functioning in ASAM domains, it is recommended that a portion of every assessment include standardized measurement tools with established reliability and validity. No standardized instrument replaces the need for a comprehensive biopsychosocial assessment as described earlier in "General Principles of Comprehensive Assessment," but standardized tools do provide a useful means of documenting severity within each domain.

In particular, the following standardized measures have been found to be useful for assessment of ASAM dimensions:

- Addiction Severity Index (ASI), 5th Edition;
- Level of Care Index (LOCI);
- Recovery Attitude and Treatment Evaluator (RAATE-CE and RAATE-QI);
- Substance Abuse Subtle Screening Inventory (SASSI);
- Substance Use Disorders Diagnostic Schedule (SUDDS-IV);
- CIWA-Ar (withdrawal potential); and
- BSI or BPRS (psychiatric symptomatology).

Other measures may also be used, as appropriate, based upon clinical setting and client need.

These measures are used widely in many clinical settings and all provide broad assessments of clinical status in one or more ASAM domains. None of these assessments provide comprehensive assessment of any single clinical domain, but they are useful for global placement and treatment planning decisions.

2D. Objective Information versus Clinical Subjectivity

Instruments that rely on objective and verifiable information from clients are recommended as superior to instruments that rely heavily on clinician inference or clinician impression. While clinical expertise is an extremely valuable asset in accurate assessment, placement, and treatment planning, many highly skilled clinicians resist intake work (TIP #13, page 37). In order to achieve a high level of inter-rater reliability across diverse clinical settings, research shows that extensive training with ongoing supervision and reliability testing is required. Clearly, clinical judgment plays an important role in the collection of accurate, reliable, objective information and in subsequent interpretation of objective data. However, objective assessment information does not replace the need for a comprehensive biopsychosocial interview.

Perhaps the most significant benefit of objective clinical information in combination with ASAM guidelines is that it facilitates communication with utilization management reviewers, providing clear standards and documentation for placement and treatment planning decisions.

2E. Use of Assessment to Guide Placement Decisions Using ASAM Criteria

The Tennessee Department of Health – Bureau of Alcohol and Drug Abuse Services endorses use of ASAM PPC-2R placement criteria for determination of appropriate level of care. ASAM PPC-2R criteria should be used as the standard by which "medical necessity" for substance abuse treatment is determined. Clinical criteria used to make placement decisions within the ASAM framework should be clearly documented within the patient record.

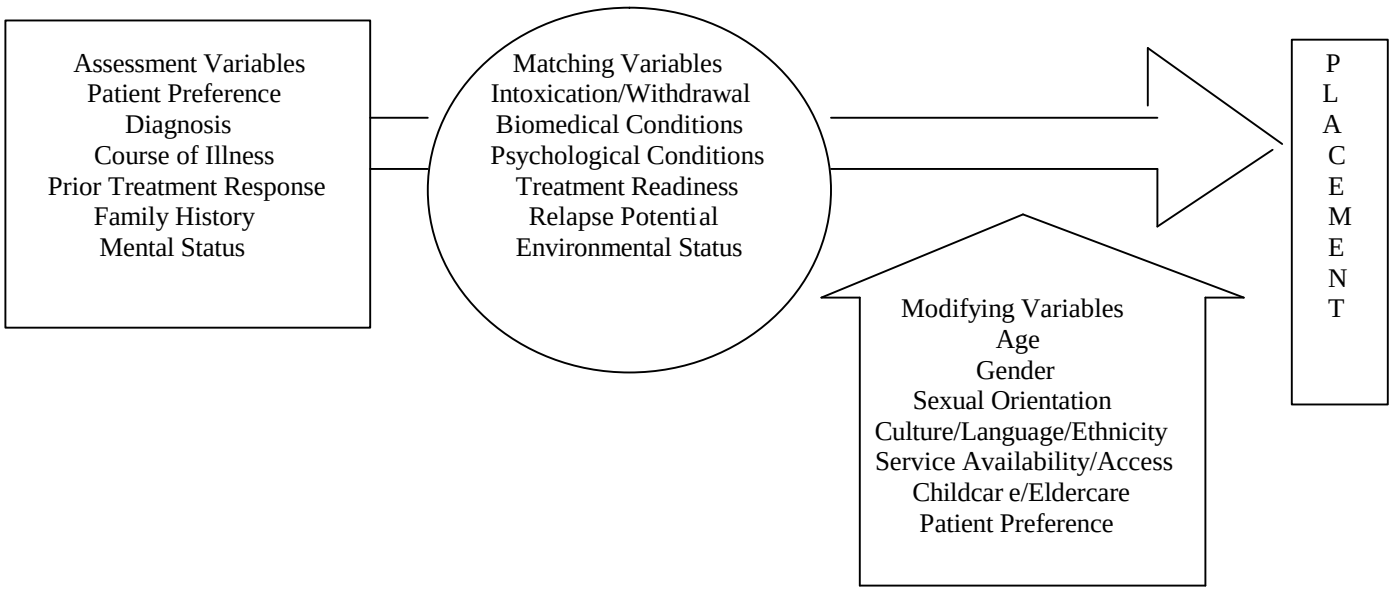
Once a comprehensive assessment has been conducted, clinical information may then be synthesized to rate clinical severity within each ASAM dimension. These aggregate ratings of severity may then be used to dictate placement in the following ASAM levels of care:

Level 0.5: Early Intervention
Level I: Outpatient Services
Level II: Intensive Outpatient/Partial Hospitalization Services
Level III: Residential/Inpatient Services
Level IV: Medically Managed Intensive Inpatient Services

Detailed descriptions of each level of care are provided in the subsequent discussion of treatment practices. Most general levels of care may be divided into more specific, more tailored levels of care with detailed guidelines regarding treatment services, staffing, and contact hours. In addition, the forthcoming ASAM PPC-2R supplies additional treatment specifications regarding treatment for co-occurring substance-related and mental health disorders.

A comprehensive assessment in each of the ASAM dimensions, in combination with other relevant clinical information available from the comprehensive assessment process, is used to make determinations regarding placement decisions. The conceptual model is shown in Figure 5-1 as follows:

Figure 5-1
Variables Considered in
Assessing and
Placing a Client



- **Assessment variables** are general characteristics that form the first level of data for input to decision rules.
- **Matching variables** are the specific data elements that are then required for multidimensional matching to a discrete level of care.
- **Modifying variables** may be used to modify the level of care determination based on intervening factors that exist within the patient or treatment system.

(The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders, Treatment Improvement Protocol (TIP) Series 13, page 36).

Specific elements of this model will vary depending upon the treatment context, client characteristics, and special considerations. The ASAM assessment framework is designed to feed naturally into an informed placement decision. A simplified version of the ASAM model provides a useful crosswalk between severity within each dimension and associated placement recommendations, shown in the adapted ASAM Crosswalk as follows:

ADULT ADMISSION CRITERIA: Crosswalk of Levels ŀIV

Criteria	Levels of Service							
Dimensions	**Level I Outpatient Services**	**Level IM Intensive Outpatient**	**Level 11.5 Partial Hospitalization**	**Level III.1 Clinically-Managed Low Intensity Residential Services**	**Level 111.3 Clinically-Managed Medium Intensity Residential Services**	**Level 111.5 Clinically-Managed Medium4ligh Intensity Residential Services**	**Level 111.7 Medically-Monitored Intensive Inpatient Services**	**Level IV Partial Hospitalization**
DIMENSION 1: Alcohol Intoxication And/or Withdrawal Potential	No Withdrawal Risk	Minimal risk of severe withdrawal	Moderate risk of severe withdrawal	No withdrawal risk	Level 111.3-13, Clinically-Managed Residential Detoxification Services	Minimal risk of severe withdrawal for Level 111.3 and III.S. If withdrawal is present, meets level 111.2-D criteria	111.7, Medically-Monitored Inpatient Detoxification Services	IV-D, Medically-Managed Inpatient Detoxification Services
					No severe withdrawal risk, but moderate withdrawal manageable in 111.2-D		Severe withdrawal, but manageable in Level 111.7-D	Severe withdrawal risk
DIMENSION 2: Biomedical Conditions and Complications	None or very Stable	None or not a distraction from treatment and manageable in Level 11. 1	None or not sufficient to distract from treatment and manageable at Level 11.5	None or stable	None or stable	None or stable; receiving concurrent medical monitoring	Patient requires medical monitoring but not intensive treatment	Patient requires 24-hour medical and nursing care
DIMENSION 3: Emotional/ Behavioral Conditions and Complications	None or very Stable	Mild Severity, with potential to distract from recovery; needs monitoring	Mild to moderate severity, with potential to distract from recovery; needs stabilization	None or minimal; not distracting to recovery	Mild to moderate severity; needs structure to allow focus on recovery	Repeated inability to control impulses; personality disorder requires high structure to shape behavior	Moderate severity; patient needs a 24-hour structured setting	Severe problems require 24-hour psychiatric care with concomitant addiction treatment
DIMENSION 4: Treatment Acceptance/ Resistance	Willing to cooperate but needs motivating and motivating Strategies	Resistance high enough to require structured program but not so high as to render O/P TX ineffective	Resistance high enough to require structured program but so high as to tender outpatient treatment ineffective	Open to,rccovery, but needs structured environment to maintain therapeutic gains	Little awareness; patient needs interventions available only in Level 111.3 to engage and keep in treatment	Marked difficulty with or opposition to treatment, with dangerous consequences if not engaged in treatment	Resistance high and impulse control poor, despite negative consequences, patient needs motivating strategies available only in 24-hour structured setting	Problems in this dimension do not qualify the patient for Level IV services
DIMENSION 5: Relapse/ Continued Use Potential	Able to maintain abstinence or control use and pursue recovery goals with minimal support	Intensification of addiction symptoms, despite active participation	Intensification of addiction symptoms, despite active participation in Level I or Level 11. 1; high likelih6od of relapse or continued use without monitoring and support	Understands relapse but needs structure to maintain therapeutic gains	Little awareness; patient needs interventions available only in Level 111.3 to prevent continued use	No recognition of skills needed to prevent continued use, with dangerous consequences	Unable to control use, with dangerous consequences, despite active participation in less intensive care	Problems in this dimension do not qualify the patient for Level IV services
DIMENSION 6: Recovery Environment	Supportive Recovery Environment and/or patient has skills to cope	Environment unsupportive, but with structure and support, the patient can cope	Environment is not supportive, but, with structure and support and relief from the home environment, the patient can cope	Environment is dangerous, but recovery achievable if Level 111. 1 structure is available	Environment is dangerous; patient needs 24-hour structure to learn to cope.	Environment is dangerous; patient lacks skills to cope outside of highly structured 24-' hour setting -	Environment dangerous for recovery; patient lacks skills to cope outside of highly structured 24-hour setting	Problems in this dimension do not qualify the patient for Level IV services

This illustration provides a simplified crosswalk between the six ASAM dimensions and recommended levels of care. For each ASAM dimension, an individual may score anywhere in the range from "no problems" to "very severe problems." If the majority of a client's ratings are in the "severe" range, a higher level of care may be indicated.

On occasion, a single dimension may play a dominant role in the placement decision. In the case of withdrawal potential, for example, a "severe" rating may dictate a Level IV placement even when the overall clinical profile does not suggest high severity. In such cases, management of medical risks due to substance withdrawal is prioritized in the placement decision process. These guidelines may be adapted for local needs in accordance with ASAM guidelines.

In order to appropriately use the ASAM criteria, an ASAM manual should be purchased from:

American Society of Addiction Medicine
4601 North Park Ave, Arcade Suite 101
Chevy Chase, MD 20815
Telephone 301/656-3920 Fax: 301/656-3815
http://www.asam.org/

The complete ASAM manual provides detailed instructions and guidelines regarding appropriate use of ASAM patient placement criteria.

3. Special Issues

3A. Assessment of Children and Adolescents

Substance use problems in children and adolescents have been the subject of far less research than in their adult counterparts, and consequently the array of assessment tools, diagnostic guidelines, and placement criteria are comparatively underdeveloped. Despite these limitations, however, it is perhaps more critical to conduct accurate and appropriate assessment of children and adolescents than it is with adults so that appropriate preventive and treatment services may be provided as early as possible. Substance use disorders in children severely limit adult potential, thus limiting adult opportunities and perpetuating an expensive health care concern across the lifespan (TIP #3).

Any clinician conducting assessments with children and/or adolescents should obtain a copy of CSAT TIP #3 and be very familiar with its contents.

The ASAM PPC-2R provides parallel placement criteria for adults and children, supplying guidelines regarding appropriate assessment considerations and subsequent placement decisions. In the ASAM framework, the general considerations for adults versus children and adolescents are roughly comparable:

- Adults and children are assessed on each of the six clinical dimensions described previously.
- Adults and children have access to similar levels of care (e.g., outpatient, residential).
- A similar reasoning process is used to crosswalk clinical judgment with placement decisions.

Despite some general similarities, there are special issues related to assessment of children and adolescents that require additional attention. As detailed in CSAT TIP #3 (page 20), recommended assessment domains include:

- alcohol and other drug use;
- over-the-counter and prescription drugs, including tobacco and caffeine;
- medical history (previous illnesses, infectious diseases, medical trauma, and STDs);
- mental Health history (previous evaluations, treatment summaries);
- family history (strengths as well as problems; AOD abuse; mental and physical health problems including chronic illness(es); involvement with juvenile or justice system; child management concerns; an understanding of the family's cultural, racial, and socioeconomic background);
- school history (learning-related problems, academic performance, behavioral performance, and attendance);
- vocational history (paid work, volunteer work in the community);
- child welfare involvement (number and length of foster home placements, residential treatment);
- juvenile justice involvement (types and frequency of involvement, attitude toward behavior that got him or her in trouble);
- sexual history (sexual abuse, sexual activity, safe sex practices, current or previous);
- peer relationships;

- gang involvement;
- interpersonal skills;
- leisure-time activities;
- neighborhood environment; and
- home environment (including substandard housing, family history of homelessness, the young person's living on the streets or in shelters, or running away from home).

Assessment of children and adolescents should be multidimensional and use multiple informants where appropriate. That said, information-gathering efforts and assessment results must be treated carefully in order to ensure compliance with Federal laws regarding confidentiality (42 U.S.C. §§ 290dd-3 and ee-3 and 42 CFR Part 2. CSAT TIP #3 provides an excellent overview of legal confidentiality and informed consent issues in Chapter 4 (pages 27-38).

A number of standardized assessment tools exist for use with adolescents that may assist in the development of an ASAM-based placement recommendation. A sampling of these tools include:

Screening (and brief interviews)

- Adolescent Drinking Index (ADI)
- Adolescent Drug Involvement Scale (ADIS)
- Drug and Alcohol Problems (DAP) Quick Screen
- Drug Use Screening Inventory – Revised (DUSI-R)
- Personal Experience Screening Questionnaire (PESQ)
- Problem Oriented Screening Instrument for Teenagers (POSIT)
- Rutgers Alcohol Problem Index (RAPI)
- Teen Addiction Severity Index (T-ASI)

Assessment (standardized questionnaires and structured interviews)

- Adolescent Drug Abuse Diagnosis (ADAD)
- Adolescent Diagnostic Interview (ADI)
- Adolescent Self-Assessment Profile (ASAP)
- The American Drug and Alcohol Survey (ADAS)
- The Chemical Dependency Assessment Profile (CDAP)
- Comprehensive Adolescent Severity Inventory (CASI)
- Hilson Adolescent Profile (HAP)
- Juvenile Automated Substance Abuse Evaluation (JASAE)
- Personal Experience Inventory (PEI)
- Prevention Intervention Management and Evaluation System (PMES)

As with adults, the use of standardized screening and assessment tools in conjunction with a comprehensive clinical interview is recommended in order to establish clinical status for making placement recommendations.

3B. Assessment of Co-Occurring Psychiatric and Developmental Disabilities

The Tennessee Department of Health – Bureau of Alcohol and Drug Abuse Services and the Tennessee Department of Mental Health and Developmental Disabilities endorse the screening, identification, and appropriate diagnosis of co-occurring psychiatric and developmental disabilities among individuals being assessed for substance abuse treatment.

The most rigorous scientific studies of the prevalence of psychiatric and substance-use disorders suggest that approximately 50% of those individuals with diagnosable substance use disorders have co-occurring mental health disorders (Epidemiologic Catchement Area Study and National Comorbidity Study). While those studies focus on the general population, other evidence suggests that the rates of co-occurring disorders within treatment programs are frequently higher than 50%.

As such, substance abuse treatment professionals in the State of Tennessee have a responsibility to screen all admissions for the presence of psychiatric, developmental, or other disabilities and to provide more comprehensive assessment as indicated (either directly or through referrals to the appropriate specialists). Formal DSM diagnoses for substance use disorders and psychiatric or developmental disabilities should be made by qualified clinicians, documented in the client's records and encounter data, and explicitly addressed in treatment planning.

4. Comprehensive Assessment Provides a Foundation for Treatment Services

As described, thorough clinical assessment is a critical first step in the provision of individually targeted and clinically optimal substance abuse treatment services. While the first assessment interview (or series of interviews) will provide much information from which to base initial placement decisions and treatment recommendations, true clinical assessment is an ongoing process of gaining familiarity with the client, his or her unique needs, and continually reevaluating treatment strategies.

Assessment and treatment (or therapy) should not be considered as separate, unrelated activities. A proper initial assessment should establish a positive, engaging relationship with the client, motivate him or her to seek necessary services, and set a clear agenda for the treatment process. Once a client enters the formal treatment setting, the entire treatment team must continue to assess changes in the client's clinical status, revising treatment plans as needed. In keeping with this philosophy, ASAM guidelines recommend ongoing reassessment on clinical dimensions 1 -6, with consequent recommendations for increasing or decreasing the level of care as appropriate.

IV. TREATMENT SECTION

TENNESSEE ALCOHOL AND DRUG BEST PRACTICE GUIDELINES

General Outline

1. Principles of Drug Addiction and Treatment

2. Goals of Intervention / Treatment

3. Levels of Care / Continuum of Care
    A. Continuum of Care
    B. Levels of Care
    C. Detoxification: Management of Alcohol Intoxication and Withdrawal
    D. Levels of Adult Treatment Services
    E. Levels of Adolescent Treatment Services
    F. General Issues Related to Treatment
    G. Case Management
    H. Other Supportive or Ancillary Services

4. Treatment Techniques, Approaches, Strategies and Components

5. Motivation and The Stages of Change

6. Counselor Competencies / Skills – Credentialing System

7. Integrated Mental Health Services for Individuals with Co-Occurring Disorders

8. Developmental Issues
    A. The Elderly
    B. Adolescents
    C. Developmental Disabilities

9. Female Clients

10. Cultural Competence – Ethnicity – Transition between Levels of Care

1. Principles of Drug Addiction Treatment

The National Institute of Drug Abuse has provided a set of principles for drug addiction treatment that is comprehensive and raises issues that should be addressed for alcohol and drug abuse services.

- No single treatment is appropriate for all individuals.
- Treatment needs to be readily available.
- Effective treatment attends to multiple needs of the individual, not just his or her alcohol or drug use.
- An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
- Counseling (individual and/or group) and other behavioral therapies are cri tical components of effective treatment for addiction.
- Medications are an important element of treatment for many clients, especially when combined with counseling and other behavioral therapies.
- Alcohol or drug-addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.
- Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term alcohol or drug use.
- Treatment does not need to be voluntary to be effective.
- Possible alcohol or drug use during treatment must be monitored continuously.
- Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help clients modify or change behaviors that place themselves or others at risk of infection.
- Recovery from alcohol or drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

(Principles of Drug Addiction Treatment: A Research-Based Guide, National Institute on Drug Abuse, National Institutes of Health, NIH Publication No. 99-4180, Printed October 1999, pages 3-5).

2. Goals of Intervention / Treatment

Treatment should result in:

- not simply stabilizing the client's condition,
- but altering the course of the client's disease.

(American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, ASAM PPC-2, 1996)

The primary goal of addiction treatment is to meet the treatment needs of the client. These needs are biological, psychological, and social in nature.

Accordingly, the effectiveness of treatment can be measured in terms of the overall biopsychosocial health of clients, including such factors as:

- decreased substance use;
- improvements in medical and physical health;
- improvements in psychosocial functioning;
- greater employment stability;
- decreases in criminal justice system involvement; and
- relapse prevention preparedness.

(Overview of Addiction Treatment Effectiveness, U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, February 1997, pages iii and 12).

3. Levels of Care / Continuum of Care

As stated in Section III. Assessment above, the Tennessee Department of Health, Bureau of Alcohol and Drug Abuse Services endorses the use of the ASAM PPC-2 framework for all publicly funded services in the State of Tennessee. This section describes the Levels of Care that should be available. First, detoxification services are described. Next, the levels of adult treatment are discussed. Third, although levels of treatment for adolescents are similar to those for adult, they must address some unique issues and are described separately. Fourth, general issues regarding treatment are presented. Finally, case management and supportive and ancillary services are described as critical components of the continuum of care.

See APPENDIX: ADULT ADMISSION CRITERIA: Crosswalk of Levels I-IV for the link between assessment and level of care decisions.

3A. Continuum of Care

The Tennessee Department of Health, Bureau of Alcohol and Drug Abuse Services endorses a comprehensive continuum of care, incorporating all levels of care described below as well as community-based support and aftercare services.

- Within and across the levels of care, there is a continuum of the severity of illnesses treated and the intensities of services provided.
- In some ways, treatment outcome research that focuses on treatment setting promotes an artificial portrayal of treatment as being either inpatient or outpatient.
- From both a research and policy perspective, it is critical to consider the various treatment settings and approaches as part of a comprehensive continuum of care, rather than as competitive strategies.

(Overview of Addiction Treatment Effectiveness, U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, February 1997, page 39).

3B. Levels of Care

A specific treatment setting can be provided in an:

- inpatient;
- residential;
- intensive outpatient;
- outpatient setting;
- or all four.

Treatment settings vary with regard to:

- the availability of specific treatment modalities;
- the degree of restriction on access to substances that are likely to be abused;
- the availability of general medical and psychiatric care; and
- the overall milieu and treatment philosophy.

Clients should be treated in the least restrictive setting that is likely to be safe and effective. Decisions regarding the site of care should be based on:

- clients' ability to cooperate with and benefit from the treatment offered;
- the need for structure and support;
- clients' ability to refrain from illicit use of substances;
- their ability to avoid high-risk behaviors; and
- the need for particular treatments that may be available only in certain settings.

  Clients move from one level of care to another on the basis of these factors and an assessment of their ability to safely benefit from a different level of care.

Commonly available treatment settings include hospitals, residential treatment facilities, partial hospital care, and outpatient programs.
(Practice Guideline for Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, Opioids, American Psychiatric Association, 1995, page 3).

Note: All of the following information regarding levels of services was taken from the ASAM Manual (American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, ASAM PPC-2, 1996).

3C. Detoxification: Management of Alcohol Intoxication and Withdrawal

- The acutely intoxicated client should be monitored and maintained in a safe environment.
- Symptoms of Alcohol withdrawal typically:
  - begin within 4-12 hours after cessation or reduction of alcohol use;
  - peak in intensity during the second day of abstinence; and
  - generally resolve within 4-5 days. Serious complications include seizures, hallucinations, and delirium.
- Clinical assessment of intoxicated clients and those manifesting signs and symptoms of withdrawal should include laboratory determination of the presence of other substances.
- The treatment of clients in moderate to severe withdrawal includes efforts to reduce central nervous system irritability and restore physiologic homeostatis, and it requires the use of thiamine and fluids, benzodiazepines, and, in selected clients, other medications.
- Once clinical stability is achieved, the tapering of benzodiazepines and other medications should be carried out as necessary, and the client should be observed for the re-emergence of withdrawal symptoms and the emergence of signs and symptoms suggestive of a comorbid psychiatric disorder.

(Practice Guideline for Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, Opioids, American Psychiatric Association, 1995, page 5).

Detoxification: Levels of Service

Dimension 1, Acute Intoxication and/or Withdrawal Potential, is the first of the six p rimary assessment areas to be evaluated in making treatment and placement decisions. The range of clinical severity in this dimension has given rise to a range of detoxification levels of service.

Level I-D: Ambulatory Detoxification without Extended On-Site Monitoring
Level II-D: Ambulatory Detoxification with Extended On-Site Monitoring
Level III-D: Residential / Inpatient Detoxification
Level III.2-D: Clinically-Managed Residential Detoxification
Level III.7-D: Medically-Monitored Inpatient Detoxification
Level IV-D: Medically-Managed Inpatient Detoxification

Level I-D: Ambulatory Detoxification without Extended On-Site Monitoring

- Level I-D is an organized outpatient service which may be delivered in an office setting, healthcare or addiction treatment facility, or in a client's home, by trained clinicians who provide medically supervised evaluation, detoxification and referral services according to a predetermined schedule.
- Such services are provided in regularly scheduled sessions.
- They should be delivered under a defined set of policies and procedures or medical protocols.

- Outpatient services should be designed to treat the client's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol) and to effectively facilitate the client's transition into ongoing treatment and recovery.

Level II-D: Ambulatory Detoxification with Extended On-Site Monitoring

- Level II-D is an organized outpatient service, which may be delivered in an office setting, healthcare or addiction treatment facility, by trained clinicians that provide medically supervised evaluation, detoxification and referral services.
- Such services are provided in regularly scheduled sessions.
- They are delivered under a defined set of policies and procedures or medical protocols.
- Outpatient services are designed to treat the client's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol) and to effectively facilitate the client's transition into ongoing treatment and recovery.

Level III-D: Residential / Inpatient Detoxification

Criteria are provided for two types of Level III residential/inpatient detoxification programs: Level III.2-D (Clinically-Managed Residential Detoxification) and Level III.7-D (Medically Monitored Inpatient Detoxification).

Level III.2-D: Clinically-Managed Residential Detoxification

- Level III.2-D (sometimes referred to as "Social Setting Detox") is an organized service that may be delivered by appropriately trained staff, who provide 24-hour supervision, observation and support for clients who are intoxicated or experiencing withdrawal.
- Clinically managed residential detoxification is characterized by its emphasis on peer and social support.
- This level provides care for clients whose intoxication/withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support.

Level III.7-D: Medically-Monitored Inpatient Detoxification

- Level III.7-D is an organized service delivered by medical and nursing professionals, which provides 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds.
- Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols.
- This level provides care for clients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care.

Level IV-D: Medically-Managed Inpatient Detoxification

- Level IV-D is an organized service delivered by medical and nursing professionals that provides 24-hour medically directed evaluation and withdrawal management in an acute care inpatient setting.

- Services are delivered under a defined set of physician-approved policies and physician-managed procedures or medical protocols.
- This level provides care for clients whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing care services.
- Twenty-four hour observation, monitoring and treatment are available.

(ASAM American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, ASAM PPC-2, 1996)

3D. Levels of Adult Treatment Services

Levels of service in the Patient Placement Criteria range from early intervention through outpatient services to medically managed intensive inpatient care. Each level of care or service describes a range of resources available to be applied within a given period of time to addiction and related problems. The levels of service described in the Criteria are:

Level 0.5 Early Intervention
Level I Outpatient Services
Level II Intensive Outpatient / Partial Hospitalization Services
Level II.1 Intensive Outpatient Treatment
Level II.5 Partial Hospitalization
Level III Residential / Inpatient Services
Level III.1 Clinically-Managed Low-Intensity Residential Services
Level III.3 Clinically-Managed Medium-Intensity Residential Services
Level III.5 Clinically-Managed High-Intensity Residential Services
Level III.7 Medically-Monitored Intensive Inpatient Treatment
Level IV Medically-Managed Intensive Inpatient Services
Opioid Maintenance Therapy

Level 0.5 Early Intervention

- Early intervention is an organized service that may be delivered in a wide variety of settings.
- These services are designed to explore and address problems or risk factors that appear to be related to substance use and to assist the individual in recognizing the harmful consequences of inappropriate substance use.

Level I Outpatient Services

- Level 1 encompasses organized non-residential services, which may be delivered in a wide variety of settings. Addiction treatment personnel or addiction-credentialed clinicians provide professionally directed evaluation, treatment and recovery services to persons with substance-related disorders.
- Such services are provided in regularly scheduled sessions of usually fewer than 9 contact hours a week.
- These services function under a defined set of policies and procedures.

Level II Intensive Outpatient / Partial Hospitalization Services

Level II.1 Intensive Outpatient Treatment

- Intensive outpatient treatment (IOP) programs generally provide nine or more hours of structured programming per week, consisting primarily of counseling and education around alcohol and other drug problems.
- The client's needs for psychiatric and medical services are addressed through consultation or referral arrangement.
- IOP differs from partial hospitalization (Level II.5) in the intensity of clinical services that are directly available; specifically, IOP has less capacity to effectively treat individuals who have substantial medical and psychiatric problems.

Level II.5 Partial Hospitalization

- Partial hospitalization generally provides 20 or more hours of clinically intensive programming per week based on individual treatment plans.
- Programs have ready access to psychiatric, medical and laboratory services.

Level III Residential / Inpatient Services

Level III.1 Clinically-Managed Low-Intensity Residential Services

- The prime example of a Level III.1 program is the halfway house.
- Level III.1 offers low-intensity professional addiction treatment services at least 5 hours a week.
- Treatment is directed toward applying recovery skills, preventing relapse, promoting personal responsibility and reintegrating the resident into the worlds of work, education, and family life.
- The services provided may include individual, group and family therapy.
- Mutual/self-help meetings usually are available on-site.

Level III.3 Clinically-Managed Medium-Intensity Residential Services

- Level III.3 programs provide a structured recovery environment in combination with medium-intensity professional clinical services to support and promote recovery.
- Interpersonal and group living skills generally are promoted in this level of care through community meetings involving residents and staff.
- Some individuals have such severe deficits in interpersonal skills and emotional coping skills that the treatment process is one of "habilitation" rather than "rehabilitation."
- Treatment of such clients is directed toward overcoming their denial of the presence and effects of addiction in their lives, as well as enhancing treatment acceptance and motivation, preventing continued use or relapse, and promoting eventual reintegration of the individual into the community.
- To achieve this, the individual is involved in a plan of continuing care to support recovery.

Level III.5 Clinically-Managed High-Intensity Residential Services

- High-intensity residential programs are designed to address significant problems with living skills.
- The prime example of Level III.5 care is the therapeutic community, which provides a highly structured recovery environment in combination with moderate- to high-intensity professional clinical services to support and promote recovery.
- Residents at this level can generally be characterized as having chaotic, unsupportive and often abusive interpersonal relationships, extensive treatment or criminal justice histories, with risk for continued criminal behavior, little or no work history or educational experience, and/or an anti-social value system.

Level III.7 Medically-Monitored Intensive Inpatient Treatment

- Level III.7 programs offer an organized service, staffed by designated addiction treatment personnel or addiction-credentialed physicians, that provides a planned regimen of 24-hour professionally directed evaluation, care and treatment for addicted clients in an inpatient settin g.
- Such a service functions under a defined set of policies and procedures and has permanent facilities, including inpatient beds.
- Level III.7 care is delivered by an interdisciplinary staff to clients whose subacute biomedical and emotional/behavioral problems are sufficiently severe to require inpatient care.
- Twenty-four hour observation, monitoring and treatment are available; however, the full resources of an acute general hospital or a medically managed inpatient treatment service system are not nec essary.

Level IV Medically-Managed Intensive Inpatient Services

- Level IV medically managed intensive inpatient treatment is an organized service, staffed by designated addiction physicians or addiction-credentialed clinicians.
- Level IV care involves a planned regimen of 24-hour medically directed evaluation, care and treatment of substance-related disorders in an acute-care inpatient setting.
- Such a service functions under a defined set of policies and procedures and has permanent facilities that include i npatient beds.
- Level IV care requires an interdisciplinary staff to care for clients whose acute biomedical, emotional or behavioral problems are severe enough to require primary medical and nursing services.
- Treatment is provided 24 hours a day, and the full resources of a general acute care hospital or psychiatric hospital are available.

In addition to the above ASAM Levels of Care, services should be available for:

Opioid Maintenance Therapy

- Opioid maintenance therapy is an organized, usually ambulat ory, addiction treatment service for opiate-addicted clients.
- It is delivered by designated addiction trained personnel or addiction-credentialed clinicians, who provide individualized treatment, case management, and health education (HIV, TB, STD).
- The nature of the services is determined by the client's clinical needs, but such services always include regularly scheduled psychosocial treatment sessions and daily medication visits within a structured program.
- OMT services function under a defined set of policies and procedures, including admission, discharge and continued service criteria stipulated by state law and regulation and the federal regulations at FDA 21 CFR Part 291.

3E. Levels of Adolescent Treatment Services

Levels of service in the Adolescent Criteria range from early intervention to medically managed intensive inpatient care. Each level of care or service describes a range of resources available to be applied within a given period of time to addiction and related problems. The levels of service described in the Criteria are:

In treating adolescents at any level of service, the more intensive the treatment required by the adolescent, the less appropriate is a treatment approach designed for adults. Additionally, in the treatment of adolescents, there is a need for adolescent programmatic services, ideally in a location that is physically separated from adult clients. Such a treatment environment should be designed to meet the special needs of adolescents.

In general, all adolescents accepted for treatment of addiction in the defined levels of care are expected to have met diagnostic criteria for a substance-related disorder in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) or other standardized and widely accepted criteria. Exceptions would involve individuals who do not meet the diagnostic criteria but whose symptoms are severe enough to warrant an additional assessment.

For additional information on adolescent levels of care, refer to the ASAM PPC-2R.

Level 0.5	Early Intervention
Level I	Outpatient Services
Level II	Intensive Outpatient / Partial Hospitalization Services
Level III	Medically-Monitored Intensive Inpatient Treatment
Level IV	Medically-Managed Intensive Inpatient Services

Level 0.5 Early Intervention

- Early intervention is an organized service which may be delivered in a wide variety of settings.
- Early intervention services are designed to explore and address problems or risk factors that appear to be related to substance use and to assist the individual in recognizing the harmful consequences of inappropriate substance use.

Level I Outpatient Services

- Adolescent Level 1 involves organized non-residential services, delivered in permanent facilities by designated addiction treatment personnel or addiction-credentialed clinicians.
- Such a program provides professionally directed evaluation, treatment and recovery services to addicted adolescents.
- Level I outpatient treatment provides a variety of programming opportunities. It may include a defined program that combines assessment, educational, therapeutic and continuing care elements.
- Such services are provided in regularly scheduled sessions of usually fewer than 9 contact hours a week.
- These services function under a defined set of policies and procedures.

Level II Intensive Outpatient / Partial Hospitalization Services

- Intensive outpatient treatment in Level II involves a structured day or evening treatment program that may be offered before or after work or school, in the evening or on a weekend.
- For appropriately selected patients, such programs provide essential education and treatment components while allowing clients to apply their newly acquired skills within "real world" environments.
- Programs have the capacity to arrange for medical and psychological consultation, psychopharmacological consultation and 24-hour crisis services.
- They provide comprehensive biopsychosocial assessments and individualized treatment plans, which include problem formulation, treatment goals and measurable treatment objectives.
- In addition, they have active affiliations with other levels of care and can assist in accessing clinically necessary "wraparound" support services, such as child care, transportation and tutoring or vocational training.

Level III Medically-Monitored Intensive Inpatient Treatment

- Level III encompasses organized services staffed by designated addiction treatment personnel who provide a planned regimen of client care in a 24-hour live-in setting.
- Such services adhere to defined sets of policies and procedures.
- They are housed in, or affiliated with, permanent facilities where clients can reside safely.
- They are staffed 24 hours a day.
- Mutual/self-help meetings generally are available on-site.
- The defining characteristic of all Level III programs is that they serve clients who need and, therefore, are placed in safe and stable living environments in order to develop sufficient recovery skills.

Level IV Medically-Managed Intensive Inpatient Services

- Level IV medically managed intensive inpatient treatment is an organized service, staffed by designated addiction physicians or addiction-credentialed clinicians.
- Level IV care involves a planned regimen of 24-hour medically directed evaluation, care and treatment of substance-related disorders in an acute-care inpatient setting.
- Such a service functions under a defined set of policies and procedures and has permanent facilities that include inpatient beds.
- Level IV care requires an interdisciplinary staff to care for adolescent clients whose acute biomedical, emotional or behavioral problems are severe enough to require primary medical and nursing services.
- Treatment is provided 24 hours a day, and the full resources of a general acute care hospital or psychiatric hospital are available.

(ASAM American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, ASAM PPC-2, 1996)

3F. General Issues Related to Treatment

Length of Treatment and Retention in Treatment

- As with other disease processes, length of service is linked directly to the client's response to treatment (e.g., attainment of the treatment objectives and degree of resolution regarding the identified clinical problems).

(ASAM American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, ASAM PPC-2, 1996, page 6)

- Perhaps the most robust and pervasive indicator of favorable post-treatment outcome in all forms of substance abuse rehabilitation has been length of stay in treatment.
- Virtually all studies of rehabilitation have shown that clients who stay in treatment longer and/or attend the most treatment sessions have the best post-treatment outcomes (Simpson & Savage, 1980; Hubbard, Marsden et al., 1989, De Leon, 1984; Ball & Ross, 1991).

(Principles of Addiction Medicine, Second Edition, American Society of Addiction Medicine, Inc, Chevy Chase, Maryland, 1998, page 330)

- Many people who enter treatment drop out before receiving all the benefits that treatment can provide. Successful outcomes may require more than one treatment experience. Many addicted individuals have multiple episodes of treatment, often with a cumulative impact.
- Since successful outcomes often depend upon retaining the person long enough to gain the full benefits of treatment, strategies for keeping the individual in the program are critical.
- Whether a person stays in treatment depends on factors associated with both the individual and the program.
- Individual factors related to engagement and retention include:
  - motivation to change drug-using behavior;
  - degree of support from family and friends; and
  - whether there is pressure to stay in treatment from the criminal justice system, child protection services, employers or the family.
- Programmatic factors would include:
  - whether or not the counselors are able to establish a positive, therapeutic relationship with the client;
  - whether or not the counselor ensures that a treatment plan is established and followed so that the individual knows what to expect during treatment; and
  - whether or not appropriate medical, psychiatric and social services are available.

(Principles of Drug Addiction Treatment: A Research-Based Guide, National Institute on Drug Abuse, National Institutes of Health, NIH Publication No. 99-4180, October 1999, page 16-17).

Discharge

- The health care professional's decision to prescribe a type of service, and subsequent discharge of a client from a level of care, needs to be based upon:
  - how that treatment and its duration will not only influence the resolution of the dysfunction,
  - but also positively alter the prognosis for long-term outcome for that individual client.

(ASAM American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, ASAM PPC-2, 1996, page 6)

- The discharging service provider should be responsible for transition planning to the next needed service and making every reasonable effort to ensure that the client makes that transition successfully.

Changing Levels of Service

- As the client moves through treatment in any level of service, his or her progress in all six dimensions should be continually assessed. Such multidimensional assessment ensures comprehensive treatment.
- As the client's response to treatment is assessed, his or her progress is compared with criteria for continued service and discharge to help identify the appropriate level of service.

(ASAM American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, ASAM PPC-2, 1996, page 7)

- Because addiction is a dynamic process, the obvious signs and symptoms of the disorder will rise and fall over the course of time. Treatment and recovery are likewise dynamic processes. As a result, when clients participate in addiction treatment, their treatment needs will change.

(Overview of Addiction Treatment Effectiveness, U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, February 1997, page 39).

- As the client changes level of service, whether within an agency or between agencies, the initial service provider should be responsible for transition planning to the next needed service and making every reasonable effort to ensure that the client makes that transition successfully.

Treatment Failure

- Individual treatment decisions should be based upon an assessment of each client.
- Therefore, requirements that a person fail one or more times in outpatient treatment before he or she can be considered for inpatient treatment is no more rational than treating all substance abusers in an inpatient program or using a fixed length of stay for all inpatients.
- In addition, failure or lack of treatment progress does not automatically indicate an admission criterion for a more intensive level of care.

- It does indicate the need to identify what strategy or intervention was less effective than planned, and what can be improved in the treatm ent plan.

(ASAM American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, ASAM PPC-2, 1996, pages 3 and 15).

Informed Consent

Health care requires informed consent, indicating that the client has been made aware of:

- the proposed modalities of treatment;
- the risks and benefits of such treatment;
- appropriate alternative treatment modalities; and
- the risks of treatment versus no treatment.

(ASAM American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, ASAM PPC-2, 1996, page 6).

Medical Necessity

- Central to judgements concerning appropriateness of care is the concept of "medical necessity."
- Because substance-related disorders are biopsychosocial in etiology and expression, assessment and treatment are most effective if they, too, are biopsychosocial.
- The six primary problem areas identified in the ASAM PPC encompass all pertinent biopsychosocial aspects of addiction that determine the severity of the client's illness.
- Medical necessity pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the client.

(ASAM American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, ASAM PPC-2, 1996, page 6).

Client Choice

- Treatment for alcohol and drug abuse problems always acknowledges that the client must be the driving force in treatment decisions.
- Clients have the right to request that treatment take place in a less restrictive, or lower level of care, that recommended by ASAM criteria in order to accommodate other responsibilities they have. If a client believes he/she should be in a more restrictive or higher level of care, a treating professional will discuss this with him/her and determine if additional information has been made available that may change the level of treatment recommendation.

3G. Case Management

The continuum of care should include the availability of case management services when needed, either by client request or provider recommendation.

Case management is:

- planning and coordinating a package of health and social services that is individualized to meet a particular client's needs;

- a process or method for ensuring that consumers are provided with whatever services they need in a coordinated, effective, and efficient manner;
- helping people whose lives are unsatisfying or unproductive due to the presence of many problems which require assistance from several helpers at once;
- monitoring, tracking and providing support to a client, throughout the course of his/her treatment and after;
- assisting the client in re-establishing an awareness of internal resources such as intelligence, competence, and problem solving abilities; establishing and negotiating lines of operation and communication between the client and external resources; and advocating with those external resources in order to enhance the continuity, accessibility, accountability, and efficiency of those resources; and
- assessing the needs of the client and the client's family, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client's complex needs.
  (National Association of Social Workers, 1992)

When implemented to its fullest, case management will enhance the scope of addictions treatment and the recovery continuum. A treatment professional utilizing case management will:

- provide the client a single point of contact for multiple health and social services systems;
- advocate for the client;
- be flexible, community-based, and client-oriented; and
- assist the client with needs generally thought to be outside the realm of substance abuse treatment.

To provide optimal services for clients, a treatment professional should possess particular knowledge, skills, and attitudes including:

- understanding various models and theories of addiction and other problems related to substance abuse;
- ability to describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related problems;
- ability to recognize the importance of family, social networks, community systems, and self-help groups in the treatment and recovery process;
- understanding the variety of insurance and health maintenance options available and the importance of helping clients access those benefits;
- understanding diverse cultures and incorporating the relevant needs of culturally diverse groups, as well as people with disabilities, into clinical practice; and
- understanding the value of an interdisciplinary approach to addiction treatment.

(Comprehensive Case Management for Substance Abuse Treatment, Treatment Improvement Protocol (TIP) Series 27, U. S. Department of of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 1998, pages xiii, xiv, and 5)

3H. Other Supportive or Ancillary Services

The continuum of care should include access to other supportive or ancillary services to meet the needs of the client to participate in treatment, benefit from treatment, and have the opportunity for a successful transition to the community following treatment. Treatment providers should link clients with any needed ancillary services that are not provided by their agency.

- The best treatment programs provide a combination of therapies and other services to meet the needs of the individual client.

- Examples of important ancillary services include:
  - child care services;
  - vocational services;
  - mental health services;
  - medical services;
  - educational services;
  - AIDS/HIV services;
  - legal services;
  - financial services;
  - housing / transportation services; and
  - family services.

(Principles of Drug Addiction Treatment: A Research-Based Guide, National Institute on Drug Abuse, National Institutes of Health, NIH Publication No. 99-4180, October 1999, page 14)

Support and ancillary services should also include access to informal support groups to sustain or promote abstinence, such as those provided by community-based and faith-based organizations.

4. Treatment Techniques, Approaches, Strategies and Components

A variety of treatment techniques, approaches, strategies and components are available for the treatment of alcohol and drug abuse problems. This section summarizes the literature available on these treatments. **The Tennessee Department of Health, Bureau of Alcohol and Drug Abuse Services endorses the use of evidence-based treatment whenever possible.**

(Changing the Conversation: Improving Substance Abuse Treatment, The National Treatment Plan Initiative, November 2000)
(Overview of Addiction Treatment Effectiveness, U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, February 1997)

Treatment Techniques

Addiction treatment is not a single, homogeneous, or uniform technique. Rather, addiction treatment includes numerous interventions, methods, strategies, and techniques with differences in philosophies, goals, and, to some degree, type of clients treated.

Treatment Approaches

Addiction treatment can be described in terms of *treatment approach* – a treatment intervention based on a specific philosophical approach. The primary approaches are:

- Methadone maintenance treatment
  Methadone maintenance treatment entails the substitution of heroin with a medically safe, long-acting medication of known purity, potency, and quantity, taken orally once daily. The medication is combined with biopsychosocial treatment services.
- Therapeutic community treatment
  The therapeutic community approach generally entails participation in a long-term, intensive program that focuses on the holistic rehabilitation or habilitation of the addicted person.
- "Traditional" Chemical Dependency Treatment
  Generally involves medically supervised detoxification in combination with a range of biopsychosocial treatment services.
- Outpatient Drug-Free Nonmethadone Treatment
  Represented by a diverse and eclectic assortment of program models that typically emphasize individual and group counseling and training in social skills.

(Overview of Addiction Treatment Effectiveness, U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, February 1997, pages iii, iv and 15).

Treatment Strategies

Treatment strategies have evolved over time, generally independent of each other. Further, there are both differences and similarities among treatment strategies, meaning that the programmatic treatment goals at two programs may be (1) the same or equivalent, (2) compatible and complementary, (3) conflicting and oppositional.

(Overview of Addiction Treatment Effectiveness, U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, February 1997, page 15).

Treatment Components

The phrase "treatment components" refers to specific clinical interventions, strategies, and procedures that are provided to achieve specific treatment goals and objectives. These components include:

- Pharmacotherapies;
- Behavioral Relationship Therapy;
- Behavioral Contracting;
- Brief Intervention Treatment;
- Stress Management;
- Social Skills Training;
- Relapse Prevention;
- Employee Assistance Programs;
- Alcoholics Anonymous; and
- Individual Psychotherapy.

Treatment components exist both within treatment programs and as stand -alone services. These include such services as screening, assessment, counseling, drug testing, tuberculosis testing, medical and psychiatric treatment, and group therapy.

(Overview of Addiction Treatment Effectiveness, U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, February 1997, pages 15-16).

Specific Types of Treatment

Psychosocial Treatments

Psychosocial treatments are essential components of a comprehensive treatment program. Available data indicate that the following forms of treatment are effective for selected clients with substance use disorders:

- cognitive behavioral therapies;
- behavioral therapies;
- psychodynamic / interpersonal therapies;
- group and family therapies; and
- participation in self-help groups.

(Practice Guideline for Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, Opioids, American Psychiatric Association, 1995, page 2).

Another Type of Intervention: Brief Advice

Another type of intervention that has begun to receive widespread attention as a broad public health response to alcohol and drug problems has been called "brief advice," "early intervention," or "brief intervention."
(Problem Drinkers: Guided Self-Change Treatment, Mark B. Sobell and Linda C. Sobell, The Guilford Press, 1993, page 9).

Pharmacologic Management

Pharmacologic treatments are beneficial for selected clients with substance use disorders. The categories of pharmacologic treatments are:

- medications to treat intoxication and withdrawal states;
- medications to decrease the reinforcing effects of abused substances;
- medications that discourage the use of substances by inducing unpleasant consequences through a drug-drug interaction or by coupling substance use with an unpleasant, drug-induced condition;
- agonist substitution therapy; and
- medications to treat comorbid psychiatric conditions.

The effectiveness of specific pharmacotherapies for alcohol-dependent clients is not well established.

- Naltrexone may attenuate some of the reinforcing effects of alcohol, but there are limited data regarding the long-term efficacy for clients with alcohol use disorders.
- Disulfiram is an effective adjunct to a comprehensive treatment program in reliable, motivated clients whose drinking may be triggered by events that suddenly increase alcohol craving.
- Clients with impulsive behavior, psychotic symptoms, or suicidal thoughts are poor candidates for disulfiram treatment.

In clients with clearly established comorbid psychiatric disorders, treatment specifically directed at these disorders is indicated. Such treatment must be coordinated with other treatments for the substance use disorder.
(Practice Guideline for Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, Opioids, American Psychiatric Association, 1995, pages 2 and 5).

Treatment Models

The development of a modern treatment system for substance abuse dates only from the late 1960's, with the decriminalization of public drunkenness and the escalation of fears about crime associated with increasing heroin addiction.

Nonetheless, the system has rapidly evolved in response to new technologies, research, and changing theories of addiction with associated therapeutic interventions.

The six models of addiction listed below have competed for attention and guided the application of treatment strategies over the last 30 years:

- Moral Model;
- Medical Model;
- Spiritual Model;
- Psychological Model;
- Sociocultural Model; and
- Composite Biopsychosocial-Spiritual Model.

(Enhancing Motivation for Change in Substance Abuse Treatment, Treatment Improvement Protocol "TIP" Series 35, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 1999, page 5-8).

5. Motivation and The Stages of Change

Motivation to change has been shown to be a critical element of a client's ability to engage in treatment. This section summarizes information on motivation and the stages of change as a resource for service providers.

Triggers to Change

- The multidimensional nature of motivation is captured, in part, in the popular phrase that a person is "ready, willing and able" to change.
- This expression highlights three critical elements of motivation.
- The clinician's approach can be guided by deciding which of these three needs bolstering.

Motivation: A Key to Change

- Motivation is:
  - a key to change;
  - multidimensional;
  - dynamic and fluctuating; and
  - influenced by social interactions and can be modified.
- Experiences such as the following often prompt people to begin thinking about making changes and to consider what steps are needed:
  - distress levels;
  - critical life events;
  - cognitive evaluation or appraisal;
  - recognizing negative consequences; and
  - positive and negative external incentives.
- Motivation is influenced by the clinician's style. The clinician's task is to elicit and enhance motivation.

The Stages of Change

It is important to recognize the stage at which the client is currently operating in order to shape treatment decisions.

There are several stages of change:

- Pre contemplation (not yet considering change or is unwilling or unable to cha nge);
- Contemplation (acknowledges concerns and is considering the possibility of change but is ambivalent and uncertain);
- Preparation (committed to and planning to make a change in the near future but is still considering what to do);
- Action (actively taking steps to change but has not yet reached a stable state);
- Maintenance (achieved initial goals such as abstinence and is now working to maintain gains); and
- Recurrence (client has experienced a recurrence of symptoms and must now cope with consequences and decide what to do next).

For most substance-using individuals, progress through the stages of change is circular or spiral in nature, not linear. Recurrence is seen as a normal event because many clients cycle through the different stages several times before achieving stable change.

Motivational Support

Clients need and use different kinds of motivational support according to which stage of change they are in and into what stage they are moving. If you try to use strategies appropriate to a stage other than the one the client is in, the result could be treatment resistance or noncompliance (example: using action strategies with a client in the precontemplation stage).

- To consider change, clients in the precontemplation stage must have their awareness raised.
- To resolve their ambivalence, clients in the contemplation stage require help choosing positive change over their current situation.
- Clients in the preparation stage need help identifying potential change strategies and choosing the most appropriate one for their circumstances.
- Clients in the action stage (the stage at which most formal treatment occurs) need help to carry out and comply with the change strategies.
- During the maintenance stage, clients may have to develop new skills for maintaining recovery and a lifestyle without substance use. Moreover, if clients resume their substance use, they can be assisted to recover as quickly as possible to resume the change process.

(Enhancing Motivation for change in Substance Abuse Treatment, Treatment Improvement Protocol "TIP" Series 35, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 1999, pages 2, 3, 19, 29, and 31-32).

6. Counselor Competencies / Skills – Credentialing System

- There is a growing body of research suggesting that the drug or alcohol abuse counselor or therapist can make an important contribution:
  - to the engagement and participation of the client in treatment; and
  - to the post-treatment outcome.
- It is not clear what distinguishes the effectiveness of a counselor.
- Perhaps the only consistent finding has been that therapists' in-session interpersonal functioning is positively associated with greater effectiveness. Among indicators of interpersonal functioning are:
  - the ability to form a helping alliance;
  - measures of the level of accurate empathy; and
  - a measure of "genuineness," "concreteness," and "respect."
- It should be noted that there are a variety of certification programs for counselors:
  - Committee on Addiction Rehabilitation (CARF);
  - Certified Addictions Counselor (CAC); and
  - other professions treating addicted clients (American Society of Addiction Medicine; American Academy of Psychiatrists in Addiction; recently added certification for psychologists through the American Psychological Association).
- These added qualification certificates are offered throughout the country, usually by professional organizations.
- While the efforts of these professional organizations to bring needed training and proficiency to the treatment of addicted persons is commendable, there are not yet any published studies validating whether clients treated by "certified" addictions counselors, physicians or psychologists have better outcomes than clients treated by non-certified individuals.
- This is an important gap in the existing literature and the results of such studies would be quite important for the licensing efforts and health policy decisions of many states and health care organizations.

(Principles of Addiction Medicine, Second Edition, American Society of Addiction Medicine, Inc, Chevy Chase, Maryland, 1998, pages 331-332)

7. Integrated Mental Health Services for Individuals with Co-Occurring Disorders

- Managed care systems must not view dual diagnosis service capacity merely as a matter of establishing a set of dual diagnosis programs.
- The high prevalence of comorbidity requires that the whole system of care must be designed to provide integrated, continuous, and comprehensive services to consumers with comorbid, (and, of course, single disorders), wherever they present.
- Consequently the first set of standards must apply to the design of the system as a whole, and must encompass the system's mission, philosophy, governance, integration, comprehensiveness, and quality management with regard to dual diagnosis.
- Managed care systems must create dual diagnosis delivery that is customer-focused and consumer/family-centered through the development of a system of care that is:
  - welcoming;
  - accessible;
  - integrated;
  - continuous; and
  - comprehensive.
- The complex needs of dual diagnosis consumers require proactive attention to integration across traditional service boundaries.
  - integration of addiction and psychiatric services;
  - integration of acute care and long-term support services;
  - integration of insured and uninsured;
  - integration of external systems;
  - children, adolescents and families;
  - adults in correctional facilities;
  - rehabilitation services; and
  - housing services.

(Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies, and Training Curricula, Report of The Center for Mental Health Services Managed Care Initiative: Clinical Standards and Workforce Competencies Project, Co-Occurring Mental and Substance Disorders Panel, January 1998, Kenneth Minkoff, M.D., Panel Chair, Executive Summary, pages 3, 5 and 6)

8. Developmental Issues

Issues regarding the developmental stage of the client must be considered when making treatment decisions about level of care, and in planning and delivering treatment. Developmental issues arise for the elderly, for children and adolescents, and for those with developmental disabilities.

8A. The Elderly

Two studies suggest that the treatment needs of older adults with alcohol use disorders may be different from those of younger clients. Liskow et al. (364) found that clients aged 58-77 required higher benzodiazepine doses during a 5-day detoxification and may need longer detoxification than clients under 33. Kofoed et al. (365) reported that VA clients aged 54 or older who received specialized services for the elderly in a VA program remained in treatment longer and were four times as likely to complete the program than elderly clients who received conventional services, although posttreatment relapse rates were comparable in the two groups. (Practice Guideline for Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, Opioids, American Psychiatric Association, Am J Psychiatry 152:11, November 1995 Supplement, page 35)

8B. Adolescents

Adolescent users differ from adults in many ways. Their drug and alcohol use often stems from different causes, and they have even more trouble projecting the consequences of their use into the future. In treatment, adolescents must be approached differently than adults because of their unique developmental issues, differences in their values and belief systems, and environmental considerations (e.g., strong peer influences).

The treatment process must address the nuances of each adolescent's experience, including cognitive, emotional, physical, social, and moral development.

Characteristics of Adolescent Treatment Services

In order to address the developmental issues of adolescents, treatment services should:

- be individualized and based on a thorough assessment;
- differ from services designed for and used by adults;
- be peer-oriented;
- recognize the adolescent's specific developmental tasks (including social development), his or her cognitive developmental level, and his or her status as a dependent member of a family system;
- be attentive to the existence of comorbidity (The majority of adolescents with a substance use disorder have histories of conduct disorder, for which multimodal intervention is often required. Comorbid mood, anxiety and eating disorders demand specific interventions as well. The significant level of comorbidity in adolescent populations with substance use disorders requires detailed assessment in coexisting psychopathology);
- be intensive and of sufficient duration to achieve changes in the client's attitude and behavior regarding substance use and related behaviors;

- be as comprehensive as possible and target multiple dysfunctional domains of an adolescent's life;
- encourage family involvement and improvement of communication among family members;
- assist adolescents and their families in developing an alcohol-free and drug-free lifestyle;
- encourage adolescents to attend self-help groups;
- be sensitive to the cultural and socioeconomic realities of the adolescents, their families, and their environment;
- participate, whenever possible, in the local system of care, including social service agencies, juvenile justice (if applicable), and the school system; and
- coordinate/provide aftercare. Aftercare (i.e., follow-up treatment in less intensive levels of care) is essential. Aftercare should reinforce the improvements and changes that have been achieved during the primary treatment.

("Practice Parameters for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders," by Oscar Bukstein, M.D., principal author, and the Work Group on Quality Issues, Journal of the American Academy of Child and Adolescent Psychiatry, 36:10 Supplement, October 1997, pages 144S – 146S).

Treatment Settings for Children and Adolescents

Levels of care that are useful in the treatment of children and adolescents with substance use disorders include:

- inpatient treatment (hospital-based or freestanding rehabilitation centers);
- residential treatment (group homes, therapeutic communities);
- partial hospitalization or day treatment; and
- outpatient treatment (with or without community treatment). Community treatment includes programs such as school-based counseling and self-help groups, as well as prosocial recreational opportunities that offer supervised activities in a presumably drug-free environment. Self-help or peer-support groups, such as AA or NA, are important adjuncts to the treatment of SUD in adolescents.

These levels of care represent successively reduced restrictiveness and intensiveness of intervention. At all levels of care, interventions should be oriented to the developmental needs of adolescents.

("Practice Parameters for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders," by Oscar Bukstein, M.D., principal author, and the Work Group on Quality Issues, Journal of the American Academy of Child and Adolescent Psychiatry, 36:10 Supplement, October 1997, page 146S).

Treatment Modalities for Adolescents

- There have been few well-controlled studies of specific treatment modalities for adolescent substance use disorders; however, there is indication that some treatment is better than no treatment (Catalano et. Al., 1990-1991)..

- Important factors for treatment success are:
  - staff characteristics (including staff attitudes and training);
  - the availability of special services; and
  - family participation.
- Length of treatment is related to reduced alcohol and drug use in residential treatment programs.
- Individual characteristics associated with noncompletion of treatment include:
  - younger age of onset;
  - more serious alcohol use;
  - the abuse of multiple drugs; and
  - deviant behavior.
- Posttreatment predictors of relapse include:
  - thoughts, feelings and cravings about alcohol;
  - less involvement in school or work; and
  - less satisfactory leisure-time activities.
- Matching clients with appropriate levels of care of specific treatment modalities has received frequent attention in the adult literature.
  - Psychiatric severity may be the best guide to matching (McClellan et al., 1983).
  - In the one published report of client-treatment matching for adolescents, Friedman and associates (1993) found a trend toward better outcome for adolescents with more severe psychiatric problems.

("Practice Parameters for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders," by Oscar Bukstein, M.D., principal author, and the Work Group on Quality Issues, Journal of the American Academy of Child and Adolescent Psychiatry, 36:10 Supplement, October 1997, page 147S).

Treatment Outcome for Adolescents

Adolescent addiction treatment outcome is a poorly studied area. Only a small number of controlled studies have addressed treatment outcomes for addicted adolescents. Most of the knowledge gained from such studies concerns predictors of treatment success or failure. This research suggests that involvement in educational programs as well as longer times in treatment is associated with the completion of treatment and overall treatment success. While limited, such information helps to make suggestions regarding treatment program components and matching clients to treatment.
(Overview of Addiction Treatment Effectiveness, U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, February 1997, page 91).

Medical Issues Regarding Adolescents

- While medical complications of substance use are uncommon among adolescents (Martin et al., 1995); clinicians and medical professionals should maintain a high level of suspicion for substance use or abuse when adolescents present for care

following accidents or trauma, because accidents and trauma commonly occur while individuals are under the influence of substances. Examples include:

- drownings;
- motor vehicle accidents; and
- bicycle/skateboarding accidents.

♦ Substance abusing adolescents are also more prone to:

- be victims or perpetrators of violence;
- engage in high risk sexual behavior; and
- be at high risk for human immunodeficiency virus (HIV) infection.

("Practice Parameters for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders," by Oscar Bukstein, M.D., principal author, and the Work Group on Quality Issues, Journal of the American Academy of Child and Adolescent Psychiatry, 36:10 Supplement, October 1997, page 144S).

Methadone Treatment for Adolescents

Some psychiatrists prefer to avoid methadone maintenance as a first-line treatment for opioid dependence in adolescents since it may become a lifelong therapy. Although therapeutic communities are sometimes recommended, most adolescents have difficulty tolerating prolonged confinement in such programs unless the programs are specifically tailored to meet the clinical needs of this age group.
(Practice Guideline for Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, Opioids, American Psychiatric Association, Am J Psychiatry 152:11, November 1995 Supplement, page 46)

Adolescent Consent for Release of Information

Two Federal laws and a set of regulations guarantee the strict confidentiality of information about persons – including adolescents – receiving AOD abuse prevention and treatment services. The legal citations for these laws and regulations are 42 U.S.C. §§290dd-3 and ee-3 and 42 CFR Part 2.
(Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents, Treatment Improvement Protocol (TIP) Series Number 3, U. S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 1993, page 27).

8C. Developmental Disabilities

The developmental status of adults and adolescents should be determined during assessment and taken into account when determining level of care and treatment planning.

9. Female Clients

Information on the natural history, clinical presentation, physiology, and treatment of substance use disorders in women is limited. Although women are estimated to compris e 34% of all persons with substance use disorders in the United States psychosocial and financial barriers (e.g., lack of child care) prevent many women from seeking treatment. Other explanations for women's underuse of alcohol and drug treatment services may include women's perception of greater social stigma associated with their abuse of drugs and alcohol..

- Once in treatment, women have been found to have a higher prevalence of primary comorbidity
- Many women with substance use disorders have a history of physical and/or sexual abuse (both as children and as adults), which may also influence treatment planning, participation, and outcome.
- Female clients also tend to have more family responsibilities and may need more help with family-related problems.
- There is evidence that increasing the focus of treatment on concerns specific to women, such as adding treatment components that specifically address women's issues and increasing female staff, improves treatment outcomes for women.

(Practice Guideline for Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, Opioids, American Psychiatric Association, Am J Psychiatry 152:11, November 1995 Supplement, page 26)

Pregnancy

Substance use during pregnancy has the following implications for both the mother the developing fetus:

- the health of the pregnant woman;
- the course of the pregnancy;
- fetal development;
- child development; and
- parenting behavior.

(Practice Guideline for Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, Opioids, American Psychiatric Association, Am J Psychiatry 152:11, November 1995 Supplement, page 25)

The most well established effect of in utero substance exposure is fetal alcohol syndrome. Reported effects of fetal alcohol syndrome in children exposed to high doses of alcohol in utero include:

- low birth weight;
- poor coordination;
- hypotonia;
- neonatal irritability;
- retarded growth and development;
- craniofacial abnormalities (including microcephaly);
- cardiovascular defects;
- mild to moderate retardation;
- childhood hyperactivity; and
- impaired school performance.

(Practice Guideline for Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, Opioids, American Psychiatric Association, 1995, page 58)

For pregnant clients withdrawing from cocaine, consideration of the use of pharmacotherapies should take into account the risks and benefits to the mother and fetus. The possibility of concurrent heroin use should be considered.
(Practice Guideline for Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, Opioids, American Psychiatric Association, 1995, page 65)

Goals of treatment of pregnant substance-using women include:

- eliminating all alcohol and drug use;
- treating any comorbid general medical or psychiatric disorders;
- guiding the client safely through the pregnancy;
- facilitating appropriate parenting behavior; and
- motivating the client to remain in treatment after delivery to minimize the risk of relapse.

(Practice Guideline for Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, Opioids, American Psychiatric Association, 1995, page 58)

The optimal therapeutic approach is nonpunitive and maintains client confidentiality. Education and counseling to help women make an informed decision about continuing or terminating a pregnancy should be made available to those who want it.
(Practice Guideline for Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, Opioids, American Psychiatric Association, 1995, page 40)

10. Cultural Competence / Ethnicity

The Tennessee Department of Health, Bureau of Alcohol and Drug Abuse services endorses culturally competent assessment and service delivery.

There is evidence that ethnicity is less important in influencing outcomes than the community structure and environment. Also, pretreatment variables, such as employment and treatment type are more important than ethnicity in influencing treatment outcomes.
(Overview of Addiction Treatment Effectiveness, U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, February 1997, page 91).

While ethnicity alone is a smaller factor in treatment outcome, the specific characteristics describing the language, customs, attribution of meaning, cultural events and beliefs of an individual are culturally sensitive factors. Knowledge of these factors may have a significant effect on establishing rapport, building a therapeutic relationship and in the delivery and acceptance of treatment. Cultural sensitivity should remain as a component of training for treatment professionals as a support for increasing identification with the client.

- Current research suggests poorer prognoses for ethnic and racial minorities in conventional treatment programs, although this may be accounted for by social class differences.
- Although there is a paucity of research on the efficacy of culturally specific programming, treatment services that are culturally sensitive and address the special concerns of ethnic minority groups may improve acceptance of, compliance with, and, ultimately, the course of treatment.
- Training of staff and efforts to incorporate culture-specific beliefs about healing and recovery should be part of a comprehensive treatment program that serves different minority and ethnic groups.

(Practice Guideline for Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, Opioids, American Psychiatric Association, Am J Psychiatry 152:11, November 1995 Supplement, page 27)

V. POLICY ISSUES

TENNESSEE ALCOHOL AND DRUG BEST PRACTICE GUIDELINES

General Outline

Recommendations

1. Benefits Package and Continuum of Care
2. Medical Necessity Criteria
3. Monitoring of Treatment and BHO Performance
4. Provision of Education to Improve Best Practice
5. Incentives to Implement Best Practice
6. Coordination of AOD, MH Benefits under the BHO and Medical Benefits under the MCOs
7. Court-Ordered treatment

1. Benefits Package and Continuum of Care

The contract with the Behavioral Health Organizations should include a benefit package that includes levels 0.5 through 4 of the ASAM Levels of Care. In addition, case management should be a benefit under the contract.

Ancillary and support services are critical to successful participation in treatment and transition to the community. If these are not included in the specific benefit package, then it should be explicitly stated that it is the responsibility of the contractor to coordinate access and referral with other community agencies who provide these services and to participate in community-wide efforts to develop/expand these services.

2. Medical Necessity Criteria

The contract with the BHO should contain a definition of medical necessity criteria that explicitly includes bio/psycho/social necessity. For alcohol and drug abuse treatment, the ASAM criteria should override other medical necessity criteria for determining level of care. [see the discussion of this issue in Section III. Assessment]

3. Monitoring of Treatment and of BHO Performance

Documentation that Treatment Conforms to ASAM Criteria

The BHO should be required to document that practice conforms to these best practice guidelines. The BHO shall provide information on every admission and change in level of care, including discharge, that demonstrates the ASAM criteria upon which that decision was based, the date of the assessment, and other circumstances surrounding the decision. Should the placement decision not be supported by ASAM criteria, there must be documentation that shows why there is a discrepancy, including reports of: client request for a lower level of care, non-availability of treatment, non-authorization by the BHO.

Data/Reports to be Sent to TCB

In addition to eligibility and encounter data as currently required by the TennCare Bureau, the BHO should be required to submit monthly reports on:

- adherence to ASAM Criteria, described above; and
- all admission and discharge information currently required of Block Grant agencies.

Data reports should be shared with the TennCare Bureau, the Tennessee Department of Mental Health and Developmental Disabilities and the Tennessee Department of Health – Bureau of Alcohol and Drug Abuse Services.

Payment Issues

The contract with the BHO should recognize difficulties that have occurred in the past regarding payment issues.

- Reimbursement to providers needs to match the amount of resources needed in the level of care.
- The authorization of substance abuse treatment should not be able to be de-authorized later in the treatment episode due to discovery of new information, such as diagnosis of mental illness or developmental disability.
- Timeliness of payment should be specified, as well as consequences for delinquent payment.

Timeliness of Authorization

Prompt access to treatment is critical in the treatment of addictive disorders in order to build on the client's level of motivation to seek treatment. For services that require prior authorization, this authorization should be available within 1 hour if the client has walked it to treatment, or within 24 hours if the request for services was made by phone and it is not an emergency situation.

Performance Indicators

The BHO should provide monthly, quarterly, and annual information on a series of performance indicators for substance abuse services. These performance indicators should include the number of individuals served, and the level of service provided, during that period. The following is a list of other possible performance indicators: access to substance abuse treatment and identification rates; number of admissions for residential inpatient services and outpatient services; case management including aftercare; and substance abuse outcomes and client status.

4. Provision of Education to Improve Best Practice

The BHO should offer regular provider education in best practices and evidence-based treatment throughout the state.

5. Incentives to Implement Best Practice

Incentives to implement best practices should be made available by the BHO to their network providers.

6. Coordination of AOD, MH Benefits under the BHO and Medical Benefits under the MCO

The contract with the BHOs and MCOs should specifically address coordination of benefits for medical, substance abuse, and mental health treatment. Individuals with co-occurring disorders should have access to not only needed treatment for all disorders, but integrated treatment. Referral and communication guidelines should be made available for providers and beneficiaries to understand the procedures for securing the information necessary for referral to another service sector, for making referrals, for authorizing these referrals, and for

coordinating care. The BHOs and MCOs should jointly fund case management for individuals with co-occurring disorders to promote the coordination of services.

7. Court Orders / Mandated Treatment

We recommend that policies be written regarding the relationship of court-ordered or mandated treatment and the BHO contract.

Court-mandated treatment plans, to be effective, must be monitored to ensure that the juvenile and family are participating as required and that the substance abuse treatment diversion is meeting their needs. Secondly, guidelines or protocols should be established to ensure the consistent sharing of information in a collaborative way between substance abuse treatment professionals and the juvenile justice system. These guidelines will assure that juvenile court judges, juvenile court case managers, and other appropriate parties are aware of the array of information-sharing concerns affecting substance abuse treatment of diverted juveniles.

Combining Alcohol and Other Drug Abuse Treatment with Diversion for Juveniles in the Justice System, Treatment Improvement Protocol (TIP) Series Number 21, U. S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, DHHS Publication No. (SMA) 95-3051, Printed 1995

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APPENDIX

Adult Admission Criteria: Crosswalk of Levels I-IV

(Enclosed)

ADULT ADMISSION CRITERIA: Crosswalk of Levels ŀIV

Criteria	Levels of Service							
Dimensions	**Level I Outpatient Services**	**Level IM Intensive Outpatient**	**Level 11.5 Partial Hospitalization**	**Level III.1 Clinically-Managed Low Intensity Residential Services**	**Level 111.3 Clinically-Managed Medium Intensity Residential Services**	**Level 111.5 Clinically-Managed Medium4ligh Intensity Residential Services**	**Level 111.7 Medically-Monitored Intensive Inpatient Services**	**Level IV Partial Hospitalization**
DIMENSION 1: Alcohol Intoxication and/or Withdrawal Potential	No Withdrawal Risk	Minimal risk of severe withdrawal	Moderate risk of severe Withdrawal	No withdrawal risk	Level 111.3-13, Clinically-Managed Residential Detoxification Services	Minimal risk of severe withdrawal for Level 111.3 and III.S. If withdrawal is present, meets level 111.2-D criteria	111.7, Medically-Monitored Inpatient Detoxification Services	IV-D, Medically-Managed Inpatient Detoxification Services
					No severe withdrawal risk, but moderate withdrawal manageable in 111.2-D		Severe withdrawal, but manageable in Level 111.7-D	Severe withdrawal risk
DIMENSION 2: Biomedical Conditions and Complications	None or very stable	None or not a distraction from treatment and manageable in Level 11. 1	None or not sufficient to distract from treatment and manageable at Level 11.5	None or stable	None or stable	None or stable; receiving concurrent medical monitoring	Patient requires medical monitoring but not intensive treatment	Patient requires 24-hour medical and nursing care
DIMENSION 3: Emotional/ Behavioral Conditions and Complications	None or very stable	Mild Severity, with potential to distract from recovery; needs monitoring	Mild to moderate severity, with potential to distract from recovery; needs stabilization	None or minimal; not distracting to recovery	Mild to moderate severity; needs structure to allow focus on recovery	Repeated inability to control impulses; personality disorder requires high structure to shape behavior	Moderate severity; patient needs a 24-hour structured setting	Severe problems require 24-hour psychiatric care with concomitant addiction treatment
DIMENSION 4: Treatment Acceptance/ Resistance	Willing to cooperate but needs motivating and motivating strategies	Resistance high enough to require structured program but not so high as to render O/P TX ineffective	Resistance high enough to require structured program but so high as to tender outpatient treatment ineffective	Open to,rccovery, but needs structured environment to maintain therapeutic gains	Little awareness; patient needs interventions available only in Level 111.3 to engage and keep in treatment	Marked difficulty with or opposition to treatment, with dangerous consequences if not engaged in treatment	Resistance high and impulse control poor, despite negative consequences, patient needs motivating strategies available only in 24-hour structured setting	Problems in this dimension do not qualify the patient for Level IV services
DIMENSION 5: Relapse/ Continued Use Potential	Able to maintain abstinence or control use and pursue recovery goals with minimal support	Intensification of addiction symptoms, despite active participation	Intensification of addiction symptoms, despite active participation in Level I or Level 11. 1; high likelih6od of relapse or continued use without monitoring and support	Understands relapse but needs structure to maintain therapeutic gains	Little awareness; patient needs interventions available only in Level 111.3 to prevent continued use	No recognition of skills needed to prevent continued use, with dangerous consequences	Unable to control use, with dangerous consequences, despite active participation in less intensive care	Problems in this dimension do not qualify the patient for Level IV services
DIMENSION 6: Recovery Environment	Supportive recovery environment and/or patient has skills to cope	Environment unsupportive, but with structure and support, the patient can cope	Environment is not supportive, but, with structure and support and relief from the home environment, the patient can cope	Environment is dangerous, but recovery achievable if Level 111. 1 structure is available	Environment is dangerous; patient needs 24-hour structure to learn to cope.	Environment is dangerous; patient lacks skills to cope outside of highly structured 24-' hour setting -	Environment dangerous for recovery; patient lacks skills to cope outside of highly structured 24-hour setting	Problems in this dimension do not qualify the patient for Level IV services